

In connexion with this scheme hundreds of letters have been received at Oxford. Only two or three have been critical, and these have offered constructive criticism—if alternative suggestions of spending his Lordship's money merit such a description. Lord Nuffield has often remarked that it is much easier to make money than to give it away—however worthy the object—without raising malice in some quarters. Potential benefactors of less foresight may be discouraged by the prospect of their generosity accentuating differences of opinion which could well be composed for the general welfare.—I am, etc.,

Pembroke College, Oxford, Jan. 7. R. R. MACINTOSH.

SIR,—It is not my business to answer the questions which Sir Frederick Menzies asks in his letter on mechanical respirators (January 7, p. 35), but I hope that the following information may allay some of the anxiety caused by the threat of the distribution of 5,000 Both apparatuses. Towards the end of last year the Medical Research Council received a letter from the Ministry of Health, dated November 2, 1938, in which it was suggested that an investigation of the relative merits of positive and negative pressure methods of mechanical artificial respiration might be a suitable subject for the Medical Research Council. While arrangements were being made for this purpose news was received of Lord Nuffield's decision to provide a large number of Both respirators. As a member of the Medical Research Council I was appointed chairman of a committee of experts, including medical officers of the London County Council, and two meetings were held before Christmas. The committee was of the opinion that continuous and rapid progress was occurring both in the design of apparatus and in the organization of services for its most effective utilization. We were given reason to believe that it was difficult to stop the wheels of mass production once they had been put in gear, but we nevertheless wrote to Lord Nuffield suggesting that the distribution of Both respirators should, in the first instance, be limited to the larger hospitals, preference being given to orthopaedic hospitals and infectious diseases hospitals. As a result of these representations I imagine that it is unlikely that the present distribution of mechanical respirators will exceed 500. Moreover, these machines will carry certain improvements, recommended mainly as a result of the London County Council experience.

The committee considers its task one of great urgency and we hope to present a report in the spring.—I am, etc.,

Radcliffe Infirmary, Oxford, Jan. 7. L. J. WITTS.

SIR,—With further reference to my letter on the above subject which appeared in the *Journal* of January 7 (p. 35), may I be allowed to put forward the following suggestions for consideration as an alternative to the "broadcast" distribution of a mechanical respirator to any hospital which chooses to apply for one:

(1) That the distribution should be limited, for the present at all events, to those hospitals which are either well-known orthopaedic hospitals or fairly large hospitals for infectious diseases, for the reason that these are the hospitals where patients requiring such mechanical aids to respiration are most likely to be found.

(2) That consideration should be given to the desirability of organizing what I may call for convenience "flying squads" at certain carefully selected geographical centres throughout England and Wales, and that at these "centres" a certain number of mechanical respirators, not necessarily of one type, should be stationed, together with the necessary trained medical, nursing, and engineering staff, ready at any

time to go out with the "respirator" to any place in the area allotted to the "centre" where it is required.

It appears to me that this would be a much more satisfactory and much more efficient and economical arrangement than a "broadcast" distribution to any hospital which chooses to ask for one. Apart altogether from these advantages there would be accumulated what we want—that is, more knowledge and experience with regard to the best design and the best way of bringing about an organization for the most effective utilization of mechanical respirators. We have a great deal to learn yet on these points, and one of the best ways is to pool experience. I submit that something of the kind of organization I have suggested above is worth thinking about, together with a central committee to act as a "clearing house."—I am, etc.,

London, S.W.3, Jan. 8.

FREDERICK MENZIES.

Ulcerative Colitis

SIR,—In the *Journal* of December 31, 1938, Dr. E. R. Cullinan (p. 1351) and Dr. Erich Wittkower (p. 1356) presented evidence of the important part played by psychological factors in the development and course of ulcerative colitis, but they underestimated the importance of infection. Dr. Cullinan recalls that ulcerative colitis was "discovered at necropsy" by Wilks in 1875, but he fails to mention that Wilks described the disease as anatomically indistinguishable from dysentery, a fact confirmed since then by all pathologists with experience of both bacillary dysentery and ulcerative colitis. The endoscopic appearance of the bowel is also identical in the two diseases.

In the following table the results of Dr. F. A. Knott's examination of the stools and proctoscopic swabs taken from sixty-one consecutive cases of ulcerative colitis at New Lodge Clinic are analysed. The importance of *B. asiaticus* was well shown in a case of regional colitis in which the organism disappeared from the stools immediately after excision of the diseased portion of the colon, in which it was found in both the lumen and submucosa directly after removal (*Guy's Hosp. Rep.*, 1937, **87**, 187).

I. <i>B. dysenteriae</i> Flexner	..	4
<i>B. dysenteriae</i> Flexner (very late lactose +, mannite +, dulcitate -, non-motile)	..	3
<i>B. dysenteriae</i> Sonne	..	1
II. <i>B. enteritidis</i> Gaertner	..	1
<i>Salmonella morgani</i>	..	11
<i>B. asiaticus</i>	..	14
III. <i>B. coli</i> variants and other coliform strains of doubtful pathogenicity:		
Parenteric bacilli (unclassified motile strains, lactose -, saccharose +)	..	11
<i>B. coli haemolyticus</i>	..	2
IV. Proteolytic strains of possible secondary pathogenic power:		
<i>B. proteus</i>	..	5
<i>B. pyocyaneus</i>	..	2
V. Virulent micrococci:		
<i>Strept. haemolyticus</i> β	..	2

Mackie has recently published a similar study of eighty-five cases of ulcerative colitis in New York, from which the following table is taken (*J. Amer. med. Ass.*, 1938, **111**, 2071):

I. Dysentery: Flexner	..	14	III. <i>B. faecalis alkaligenes</i>	..	15
Sonne	..	6	<i>B. proteus</i>	..	14
Shiga	..	1	<i>B. pyocyaneus</i>	..	12
II. <i>Salmonella</i>	..	45	IV. <i>Strept. haemolyticus</i> β	..	14
<i>B. morgani</i> No. 1	..	16			

My conclusion from a study of the clinical history, endoscopic appearance, morbid anatomy, and bacteriology of ulcerative colitis is that it is a sequel of an acute or subacute infection of the colon with one of the many organisms capable of producing the "bloody flux," a disease which has been endemic in Great Britain since the

fourteenth century and is still common in all parts of the country (A. F. Hurst and F. A. Knott, *Lancet*, 1936, 2, 1197). It is liable to become chronic and develop into "ulcerative colitis" in individuals who are predisposed by their anatomical, biochemical, and psychological make-up.—I am, etc.,

New Lodge Clinic, Windsor Forest, ARTHUR F. HURST.
Jan. 7.

Radiotherapy for Metrorrhagia

SIR,—In your issue of January 7 (p. 35) Dr. Elizabeth Hurdon draws attention to the warning (*Journal*, December 24, 1938, p. 1327) issued by the Marie Curie Hospital respecting the radiological treatment of metrorrhagia in young women. She says: "The remarks were especially intended to suggest that the custom of giving an excessively large radium dosage in order to sterilize the patient is to be deprecated because of the assumption of the possibility of the inheritance of irreversible gene mutations resulting in abnormal births."

One is tempted to ask, Whose custom is this? and, What is the necessity for this warning? Such mutations have never been produced in human embryos, and surely if the radiation is of sufficient intensity to sterilize the patient irreversible gene mutations will not occur, and if the radium produces the destructive lesions she describes in her concluding paragraph, necessitating hysterectomy, there is still less to fear from this aspect, though much to fear for the patient from radium treatment. What is important, however, is the truth of her statement that "there is no question as to the value of radiation treatment when properly applied in suitable cases; there is also no doubt that it is definitely preferable to hysterectomy for persistent haemorrhages." But I would draw attention to the fact that, properly applied, radiation in these cases does not include the exhibition of radium or necessitate the so-called deep x-ray therapy, both of which are frequently followed by ill effects even of the severity which Dr. Hurdon describes.

Simple metrorrhagia and metrorrhagia associated with fibroids respond so favourably to superficial x-ray therapy without producing the slightest reaction other than improvement noticeable to the patient that it should be regarded as a specific. With this treatment I have never known one failure or one unpleasant reaction, and the patients treated remain most grateful friends.

Unfortunately, reports of radium and deep x-radiation clinics, as in the case of the Marie Curie Hospital Report, draw attention in the preamble to lesions produced by radium and deep x-radiation which are destructive and often agonizing in character, resulting in some cases in exquisite torture to the patient who previously had a relatively painless lesion; yet in the analysis of results such reports give the years of survival or percentage cured, but no percentage of the cases showing unfortunate or disastrous response to radiation. The late Mr. Percy Furnivall told us (*Journal*, February 26, 1938, p. 450, and March 12, 1938, p. 589): "I would not wish my worst enemy the prolonged hell I have been through with radium neuritis and myalgia for over six months," and that the numerous letters he received "show that the disastrous results occur more frequently than I had any idea of." The full value of his personal account will have been wasted if the reports of therapy departments fail to include a full account of the damages as well as the benefits of radiation.

We know that many simple conditions such as metrorrhagia and fibroids and a very few malignant lesions

respond so favourably even to the so-called superficial x-radiation that it may be regarded as a specific cure, but it is very doubtful yet whether the risks of intensive or prolonged radiation justify the enthusiasm which is sometimes displayed.—I am, etc.,

Birmingham, Jan. 7.

JAMES F. BRAILSFORD.

Circumcision

SIR,—My great respect for Mr. Kenneth Walker may be shared by others, and it is this consideration that prompts me to make comments on the subject of circumcision, which is dealt with by Mr. Walker in your issue of December 31, 1938 (p. 1377). In my opinion the decision that circumcision should be performed on an infant or child can but rarely be made by a surgeon, and this opinion is strengthened by the way in which Mr. Walker obviously respects psychological theories and yet fails to come to grips with the real clinical problems. He includes this paragraph:

"It should be borne in mind that psychologists are disposed to lay great emphasis on the psychological trauma that may result from the carrying out of circumcision on children. Care should therefore be exercised not to frighten a nervous child; and generally it is advisable to make use of some such basal narcotic as nembutal, paraldehyde, or avertin."

For this we must be grateful, but how much more understanding than this is required of the doctor if he is to avoid doing more harm than good! Mr. Walker writes:

"Because of the disability that may arise in later life, circumcision should always be carried out in an infant with a congenital phimosis—that is to say, with a prepuce that cannot easily be retracted over the glans penis."

This is indeed an extraordinary statement. So far as I know it is true of a large proportion of little boys that the prepuce cannot easily be retracted, and yet at 4 or 5 years or in early puberty the maturation processes provide for normal function in this as in other respects. Why not wait for this natural development? And it is surely a queer indication for an operation on a baby that he may one day be liable to venereal disease! When I am looking at a baby and contemplating the infinite complexity of his immediate and prospective physical and emotional development, I do not find myself being anxious about the possibility of his contracting syphilis or gonorrhoea in twenty years' time.

As for the psychological considerations, these simply cannot be squashed into the words: "Care should be exercised not to frighten a nervous child." If, as I believe, the emotional development of the infant is highly complex and a constant struggle on his part to get management of violent excitements, violent fears, violent rage, violent despair, then any interference that can be avoided must be avoided. It is not that the operation of circumcision is in itself always worse than any other; at a very early age penis sensation may not be so highly organized as mouth and skin and other sensations. But the whole operation is nearly always a big event, and when (as one often does) one finds that a baby has changed in character since circumcision, one has to look to the screaming and the baby's loss of confidence in his mother for the actual trauma.

The worst part, however, seems to me to be the after-care, which is seldom described by the surgeons, who nevertheless still tend to leave hospital circumcisions to the recently qualified residents. I wish to emphasize the fact that I have seen a great deal of acute distress in mothers and babies during the weeks following circum-